STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

April 23, 1986

TO: All County Welfare Directors
All County Administrative Officers

Letter No.: 86-23

SUBJECT: REVISED MEDICAL REGULATIONS - VERIFICATION OF DISABILITY (R-18-85)

Attached are copies of revised Medi-Cal regulations regarding verification of disability. This regulatory change was filed on April 18, 1986 and is effective immediately. A copy of the revised regulation and Medi-Cal Eligibility Procedures Manual (MEPM) sections are attached. The revised MEPM sections will be released under separate cover.

This regulation revision includes the revised presumptive disability standards which have been modified and expanded to include several categories of impairments not previously considered. Please read the attached MEPM section 4C carefully prior to implementing the new presumptive criteria for a complete description of each new impairment.

If you have any further questions, please contact Toni Bailey at (916) 324-4953.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: July 31, 1986

(1) Amend Section 50167 to read:

50167. Verification -- Prior to Approval.

(a) With regard to information on the Statement of Facts, the county department shall obtain verification of the following items in the manner specified below, prior to approval of eligibility:

(1) Blindness, as determined in accordance with Section 50219, and federal disability, as determined in accordance with Section 50223 (a) (1) or (b), shall be verified by any of the following methods:

(A) By determining that the person was eligible as an MN person on the basis of blindness or disability in December 1973, and that there has been continuing eligibility since that time.

(B) By obtaining verification that a prior determination of blindness or disability is still valid. ~~This~~ Verification shall be ~~obtained~~ documented by viewing any of the following or similar items, and noting in the case record the date of the award letter or notification and the disability onset and reexamination dates:

1. A Social Security Administration Title II ~~or SSI/SSP~~ award letter indicating receipt of disability benefits provided the reexamination date has not passed or a reexamination date is not indicated~~,~~ and the applicant is still receiving those benefits.

2. A Social Security Administration notification that Title II disability benefits have been increased or decreased~~,~~ provided the applicant is still receiving those benefits.

3. A Railroad Retirement Board notification of a disability award~~,~~ provided the applicant is still receiving those benefits.

4. A signed statement from the Social Security Administration that states that the person is eligible for Title II benefits on the basis of a disability.

5. Documentation of a prior determination of disability under the ~~EVH or~~ MN program, if the determination was ~~done after December 1973,~~ performed within the last six months unless:

a. The reexamination date has passed.

b. The applicant indicates his/her physical or mental condition has improved.

6. Data on the SDX ~~which shows~~ or a signed statement from the Social Security Administration indicating that a person ~~entering~~ ~~LTC~~

was discontinued from SSI/SSP for reasons other than cessation of disability~~.~~ provided the procedures specified in (D) are followed within twelve months of the SSI/SSP discontinuance date.

~~(C) By viewing a Social Security Administration Title II check that states that the payment is on the basis of disability. In this case, disability shall be further verified within 60 days by one of the methods specified in (B) or (E) of this section.~~

~~(B)~~ (C) By obtaining a letter from a physician verifying any one of the following conditions, provided the procedures specified in ~~(E)~~ (D) are followed after eligibility is determined.

1. ~~Terminal~~ Cancer~~.~~ which is expected to be terminal despite treatment.

2. Paraplegia or quadriplegia.

~~3. Absence of both eyes.~~

~~4.~~ 3. Severe mental retardation with an IQ of less than 50.

~~5.~~ 4. Absence of more than one limb.

5. Amputation of a leg at the hip.

6. Total deafness.

7. Total blindness.

8. Hemiplegia due to a stroke providing the stroke occurred more than three months in the past.

9. Cerebral palsy, muscular dystrophy or muscle atrophy with marked difficulty in walking requiring the use of two crutches, a walker or a wheelchair.

10. Diabetes with the amputation of one foot.

11. Down's Syndrome with an IQ of 59 or less.

12. End stage renal disease requiring chronic dialysis or kidney transplant.

13. A diagnosis of Acquired Immune Deficiency Syndrome (AIDS) confirmed by reliable currently accepted tests with one of the secondary conditions recognized by the Social Security Administration as establishing presumptive disability due to AIDS.

~~(E)~~ (D) By following procedures established by the Department of Social Services, Disability Evaluation Division. All necessary information shall be submitted to that division not later than 10 days after the receipt of the Statement of Facts by the county,

except in the event of a delay due to circumstances beyond the control of the county.

(a)(2) through (c)(43) unchanged.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.
Reference: Sections 14005.7 and 14051, Welfare and Institutions Code.

4A -- COUNTY PROCEDURES
DISABILITY DETERMINATION REFERRALS

Medi-Cal eligibility for federally disabled persons and Substantial Gainful Activity (SGA) Disabled persons is determined concurrently by: (1) county welfare departments (CWDs) and (2) the State Programs Bureau of the Disability Evaluation Division (DED) in the State Department of Social Services. The CWD is responsible for the nonmedical part of the eligibility determination; DED is responsible for the collection of medical data and the disability determination. (Reference: California Administrative Code (CAC), Title 22, Section 50167 (a) (1) (E)).

DED does not do incapacity determinations or pregnancy verifications nor do they verify Social Security numbers.

Disability should be determined or verified in accordance with these procedures at each application regardless of previous disability determinations for any case.

I. FEDERAL DISABLED PERSONS -- BACKGROUND

Title 22, Section 50223, defines a person 18 years of age or over as federally disabled if that person meets the disability criteria of Title II/Title XVI of the Social Security Act. (Disability status established through State Disability Insurance (SDI), Veterans' Benefits, Workers' Compensation Fund, etc., does not establish disability for Medi-Cal.) State law requires that Medi-Cal clients 21 through 64 years of age who meet this definition must have their eligibility evaluated under the Aged, Blind and Disabled-Medically Needy (ABD-MN) Program. This is due to the fact that the Medi-Cal costs of MN eligibles are approximately 50 percent federally funded, and the ABD-MN Program is more advantageous to the applicant/beneficiary due to the greater income deductions.

In addition to the required disability determination for adults who are potentially disabled, a determination is done on other Medi-Cal applicants or beneficiaries who are eligible under another program (Aid to Families with Dependent Children-MN (AFDC-MN) Program, Medically Indigent Child Program, etc.) and who allege disability and choose to apply or be redetermined as disabled MN. A child who is determined to be disabled may have a lower share of cost than an AFDC-MN child due to the greater income deductions available to both the child and his/her parents. In most cases, disability determinations occur only after Medi-Cal Only clients (applicants or beneficiaries) have identified themselves as potentially disabled through their statements on the MC 210 form or the MC 176S form. A Medi-Cal applicant/beneficiary may also identify himself/herself as potentially disabled through other written or oral statements.

There are methods other than the disability referral process to confirm a client's alleged disability. The disability referral process is used only if (1) the applicant's alleged disability cannot be confirmed by any of the other methods described in the Medi-Cal Eligibility Manual, Section 50167 (a) (1), (A) through (C), or (2) the applicant is a former Supplemental Security Income (SSI) recipient discontinued for reasons other than cessation of disability and who does not currently receive Title II benefits (see Procedure 4B).

Please note that a blindness evaluation for former SSI/State Supplementary Payment (SSI/SSP) recipients for a determination under the Pickle Amendment to the Social Security Act may be necessary even if the applicant/beneficiary has reached age 65 or has already been determined to be disabled. This is because blind individuals are entitled to a higher SSI/SSP payment level than disabled or aged persons. The worker must indicate "Pickle Person" on the MC 221 under Comments or DED may reject the referral as unnecessary.

II. DISABILITY REFERRALS

A. General

Referrals are initiated by sending a disability evaluation packet to the state DED. The packet contains completed and partly completed forms filled out by the client or the eligibility worker (EW). DED uses these forms and other information to make an evaluation. DED sends the MC 221 with results of the evaluation to the CWD. For those applicants found not disabled, DED will send a notice that must be either attached to or incorporated with the county's Notice of Action which will explain the basis for the determination. A copy of this notice must be retained in the case file.

B. Potentially Disabled Persons

If other methods of verification of disability are not available, initiate a DED referral on any applicant or beneficiary who is potentially disabled except for (1) persons who have been found not disabled or no longer disabled in the last 90 days (unless the applicant alleges his/her condition has deteriorated), (2) documentation shows the applicant was determined disabled under the MN program within the last six months unless the reexamination date has passed or the applicant indicates his/her condition has improved, and (3) persons already classified as aged or disabled unless a blindness evaluation for Pickle is required. Potential disability is indicated by any of the following:

1. The applicant/beneficiary has checked "yes" on Question 9b, page 2, of the MC 210, Statement of Facts, for Medi-Cal.

2. The applicant/beneficiary states on the MC 176S status report that he/she is now disabled.

3. The applicant/beneficiary makes a written or oral statement to the CWD which alleges disability.

NOTE: County EWs should not hesitate to tactfully discuss a disability referral with an applicant/beneficiary who does not specifically meet the criteria for referral listed above, but who could be disabled (e.g., client confined to a wheelchair; client has difficulty walking, standing, sitting; client seems disoriented to time, place, person; client exhibits extreme emotional distress; etc.).

The county is required to submit the disability evaluation packet to DHD no later than ten days after the MC 210 form or other applicant/beneficiary's statement of disability is received by the county. If medical records are readily available, they may be submitted with the packet. However, in no case should submission of the packet be delayed to obtain those records.

Content of Disability Evaluation Referral Packet:

1. MC 221, Disability Determination and Transmittal.

2. MC 223 (9/85), Applicant's Supplemental Statement of Facts for Medi-Cal.

3. MC 220, Authorization of Release of Medical Information, as appropriate.

4. Copy of the CA 1 (as required).

C. Persons With Title II or Title XVI Disability Evaluation Pending

If a client states that he/she has a Title II or Title XVI disability (including blindness) determination pending, submit a complete package to DHD indicating Title II/Title XVI pending status.

D. Disability Onset Date for Three Months Retroactive Medi-Cal Coverage of Title XVI Recipients

To request disability onset dates for Title XVI disabled or blind recipients who request three-month retroactive Medi-Cal coverage:

1. Contact the local Social Security Administration (SSA) to determine onset date. If the onset date provided by SSA is after the month(s) of request for retroactive coverage, a referral to DED will be necessary.

2. Send the referral to the appropriate DED office with the "Retro Onset" box on the MC 221 checked (see addresses in Part F). A county contact and phone number must be designated on the form.

E. Medical Reexaminations for Disabled-MN Persons

1. If a reexamination date has been established by SSA for a Title II recipient, the county must reverify disability with SSA within 60 to 90 days following the reexamination date. SSA reexamination results are not to be verified by submission of a packet to DED.

2. For each Medi-Cal Only beneficiary with a medical reexamination date indicated by DED on the MC 221 form:

   a. The county must submit, in the reexamination month, a copy of the previous MC 221 form and a newly completed disability determination packet (MC 220s, MC 221, and MC 223). If the previous MC 221 is not available, the new MC 221 should note that this is a reexamination and the date of the original disability allowance.

   b. The county must initiate the appropriate changes upon receipt of the disability determination.

3. Any beneficiary who was determined to be disabled and whose condition appears to have changed must be referred for a medical reexamination regardless of whether a reexamination date was established by DED (see IV below).

III. SGA DISABLED PERSONS

CAC, Title 22, Section 50223, defines an SGA Disabled person as a person who was an SSI/SSP disabled recipient, became ineligible for SSI/SSP because of SGA (employment), and still has the medical impairment which was the basis of the SSI/SSP disability determination.

A beneficiary's SGA Disabled status will continue even if he/she stops working, as long as the person continues to suffer from the same medical impairment. If the beneficiary's unemployed status continues long enough, he/she may then be eligible for the Medi-Cal federally disabled program or for Title XVI.

The SGA Disabled program does not apply to blind individuals since persons are federally blind strictly on the basis of visual acuity regardless of whether the individual is, or may be, employed.

Following are county procedures for processing disability determination referrals for SGA Disabled applications.

A. Referral Process

If an applicant indicates on the Statement of Facts for Medi-Cal, MC 210 form, that he/she has been discontinued from SSI/SSP disability but that he/she is still disabled and is working, determine whether the person went to work before SSI/SSP discontinuance.

1. If he/she did not go to work, there is no SGA Disabled eligibility. Process the case using the normal disability evaluation referral procedures.

2. If he/she did go to work, check the SDX listing for the month after the last month of SSI/SSP based Medi-Cal eligibility.

3. If the SDX shows the person was discontinued because of SGA (payment status code NO7), submit an SGA Disability determination packet to DED as described in 5 below.

4. If the person's SDX record shows discontinuance for reasons other than SGA or if no SDX record exists, submit an SGA disability determination packet as described in 5 below. Indicate that the referral is for both a disability evaluation and an SGA Disabled evaluation.

5. An SGA disability determination packet contains:

   a. MC 221 -- Indicate on the MC 221 form that the referral is an SGA Disabled applicant and the date of SSI/SSP discontinuance.

   b. MC 223 -- Indicate on the MC 223 form what physical or emotional problem the applicant had when his/her SSI/SSP claim was approved.

   c. MC 220 -- As appropriate.

   d. A copy of the CA 1 (as required).

6. Send the completed disability determination packet to DED no later than ten days after the completed MC 210 form has been received by the county.

B. Disability Onset Date for Three-Month Retroactive Medi-Cal Coverage for SGA Disabled

The county shall verify three-month retroactive Medi-Cal coverage for SGA Disabled applicants or recipients who request retroactive eligibility by checking the disability onset date on the MC 211 form and indicate the months of requested coverage.

C. Medical Reexamination for SGA Disabled Persons

For each beneficiary with a medical reexamination date indicated on his/her MC 221 form:

The county shall submit, in the reexamination month, a copy of the most recent MC 221 form and a newly completed disability evaluation packet (MC 220, MC 221, and MC 223). If the most recent MC 221 is not available, the new MC 221 should note that this is a reexamination and contain the date of the original SGA disability determination.

D. SGA Disabled Beneficiary Whose Employment Terminates

1. Advise an SGA Disabled beneficiary that has not applied for Title XVI to reapply for benefits at SSA since Title XVI disabled eligibility may be reestablished due to unemployed status.

2. Submit a complete disability determination packet (MC 221, MC 223, and MC 220) to DED to verify the beneficiary's SSI/SSP application and continued disability status. Provide a statement on the MC 221 form informing DED of the SSI/SSP application status for the SGA Disabled beneficiary.

IV. REEVALUATION OF DISABILITY DUE TO POSSIBLE CHANGE IN CONDITIONS

A person's disability must be reevaluated when there is a possibility that the person's condition has improved even though the DED evaluation shows no reexamination date. The county must indicate the reason for the referral on the MC 221. A full disability evaluation referral packet is required. The following are examples of situations in which a new DED referral should be made:

A. It appears to the EW that a beneficiary's condition has improved or the beneficiary reports such an improvement.

B. A disabled beneficiary becomes employed (either paid, unpaid, or volunteer work).

C. A disabled beneficiary goes off Medi-Cal for any reason other than cessation of disability for six or more months.

D. A beneficiary determined to be disabled by DED is subsequently denied SSI or RSDI due to lack of disability.

E. Disabled applicants under age 65 that do not receive Title II disability and were discontinued from SSI/SSP for reasons other than cessation of disability even though there was no SSA reexamination date (see Procedure 4B, DED Referrals for Disabled Former SSI/SSP Recipients).

In these cases the procedure set forth in II.E.1 above must be followed and the beneficiary continues to receive Medi-Cal pending the reexamination provided he/she cooperated with DED and continues to meet all other eligibility criteria.

V. DISABILITY EVALUATION FORMS

A. MC 220 -- Authorization for Release of Medical Information

A signed MC 220 is required for each relevant treatment source. Only one treatment source may be designated per signed release. A relevant treatment source is one who has treated the applicant for a significant medical problem(s).

The MC 220 is printed in Spanish on the reverse side. However, the English side must be completed in all cases. Editions dated prior to 10-78 are not acceptable due to changes in state law. Improperly completed MC 220s will be returned because treatment sources will refuse to release records without a properly completed, unaltered medical release.

Please note the following prior to submitting an MC 220:

1. No alterations, whiteouts, or other changes may be made to the MC 220. Any MC 220 showing such changes will be rejected by DED.

2. The "I hereby authorize" line must be completed with the name of the applicant's doctor, hospital, or clinic where he/she has been treated and not DED or the CWD. State law prohibits an applicant from signing a blank form.

3. Authorization is good for only 90 days from the date the MC 220 is signed. Forms signed and dated more than 90 days prior to the date DED receives them are not acceptable and will be returned.

4. The applicant's own signature is required unless he/she is under age 18 or incapable of signing.

   a. If the applicant has a public guardian or conservator, the release must include:

      (1) The signature of the public guardian or conservator.

      (2) The relationship to the applicant (i.e., legal guardian, conservator, etc.).

   b. If the applicant is mentally or physically incapable of signing the form and does not have a guardian or conservator, the form must include:

      (1) The signature of the person acting on the applicant's behalf.

      (2) The relationship to the applicant, i.e., mother, brother, sister, friend, etc.

(3) The reason the applicant cannot complete and sign the form.

c. If the applicant can only sign with an "X" or other unrecognizable format (i.e., non-English characters), the form must include:

(1) The signature or mark of the applicant.

(2) The signature of a witness.

(3) The relationship of the witness to the applicant.

d. If the applicant is under age 18, the form must include:

(1) The signature of a parent or guardian unless the minor is emancipated.

(2) The relationship to the applicant.

B. MC 221 -- Disability Determination and Transmittal

This form serves as the transmittal and determination document between the CWD and DED. It is also used to notify DED of changes in the applicant/beneficiary status such as a change in address, withdrawal of application, discontinuance, etc. This information should be included in the "CWD Representative Comments" section.

1. Social Security Number -- Indicate the applicant's Social Security number or "Pending" if his/her application for a Social Security number is pending. MC 221s submitted without a Social Security number or explanation will be returned to the county.

2. Date Applied -- This should reflect the most recent CA 1 received by the CWD or the date the applicant made the oral or written statement that he/she is disabled.

3. CWD Representative Comments -- Enter observations about the applicant's physical appearance or mental status (e.g., loss of limb, disoriented). This space can also be used for other noteworthy remarks about the applicant (e.g., AKA, sponsor's Social Security number, request for expeditious handling, dates of prior MN or SSI/OASDI applications, or contact with rehabilitation or other social service agencies, etc.).

If the applicant is receiving or has applied for disability under another Social Security number, please indicate the Social Security number in the CWD Representative Comments section.

4. Type of Referral -- Note the type of referral.

5. SGA -- Note if SGA Disabled referral. If yes, give the date of the SSI/SSP discontinuance.

6. Hospitalization -- Check as appropriate.

7. Sign and date the form and enter telephone number of the CWD representative.

8. DED may complete the disability portion of the MC 221 or may show the disability evaluation results on an attachment.

   a. Medical Determinations by DED

      (1) "Is disabled" or "is blind" checked indicates that, based on the DED medical/vocational development, the applicant is disabled under MN criteria. The onset date provided will take into consideration any request for up to three months retroactive coverage prior to the date of application.

      (2) "Is not disabled" or "is not blind" checked indicates that, based on the DED medical/vocational development, the applicant does not meet MN disability criteria.

      In this situation, the applicant/beneficiary is to be denied or discontinued if disability is the only basis of eligibility. Eligibility under any other program must be determined prior to discontinuance.

   b. No Determination Cases

      (1) Failure to Respond/Whereabouts Unknown. If the applicant has not responded to telephone/mail correspondence, or if DED is unable to locate him/her, DED will not make a disability decision. If a more current address is known to the county, it should be provided to DED. If not, the applicant is to be denied or discontinued if disability is the only basis for eligibility.

(2) Withdrawal of Application. If the applicant requests withdrawal of application for Medi-Cal, DED will not make a disability decision.

c. No Decision Cases

(1) Medical/vocational development has begun, but the evaluation process cannot be completed. An explanation as to why there is no decision will be included in the "Basis for Determination" section. The CWD should take appropriate action based on this information, i.e., deny, discontinue, or determine eligibility under any other program.

(2) If the evaluation cannot be completed due to insufficient information (lack of death certificate, etc.), the case will be returned to the CWD. The CWD should take appropriate action based on this information, i.e., attempt to obtain needed information and rerefer to DED, deny/discontinue case, etc.

C. MC 223 (9/85) -- Applicant's Supplemental Statement of Facts for Medi-Cal

The MC 223 is:

1. Designed for completion by the applicant not the EW; however, the EW should assist the applicant/beneficiary as needed.

2. Available in English and Spanish.

3. The MC 223 is used as a tool by DED and therefore should be as complete as possible. If necessary, further information about the applicant's medical/vocational history will be obtained during DED's evaluation. However, because this requires DED to contact the applicant, case delays may result. Therefore, please stress to the applicant the importance of complete information.

4. The following items on the MC 223 are essential in the disability evaluation process and should be brought to the attention of the applicant:

Part I:

a. Item 3 -- Complete date of birth, including year.

b. Item 4 -- Current height and weight.

c. Item 5 -- Applicant is to indicate the nature of his/her impairment(s) and should indicate any condition which impairs his/her ability to function regardless of whether medical treatment is desired or has been received for that condition. Additional pages may be attached.

d. Item 7 -- Applicant is to discuss all impairments and restrictions in ability to function regardless of whether the applicant views the restriction as minor. The combined effect of all impairments may render the applicant disabled. Example: An applicant completes the disability packet stating that the basis for disability is a back impairment. The applicant also wears glasses. DED evaluates the applicant and determines that the applicant's back impairment limits him/her to sedentary work which, considering age, education, and past work skills, results in a finding that the claimant is not disabled. If DED has not been informed that the applicant wears glasses, the evaluation stops there and disability is denied. However, if DED has been informed of the visual impairment, they will also consider the effect of that impairment on the applicant's ability to work. Many persons who wear glasses have visual impairments which, when corrected (glasses), still do not have 20/20 vision. Therefore, an applicant restricted to sedentary work due to back problems who has a corrected visual acuity of 20/80, for instance, in each eye will also probably be unable to perform sedentary work because he/she cannot be expected to perform work requiring a lot of reading and writing. Therefore, the applicant would probably be found to be disabled based on the additional visual impairment.

e. Item 8 -- Enter complete name(s) and address(es) of all doctor(s), clinic(s), and/or hospital(s). Include ZIP codes when possible.

Item 8A -- Enter all testing performed, even if applicant does not know purpose of test or name. If purpose or name of test is unknown, enter "unknown test" in other and give name of testing facility and date.

f. Item 9 -- It is very important that applicants complete this area. Other agencies may have relevant medical evidence gathered or have ordered a consultative examination. This evidence may help establish duration and/or the extent of the impairments. NOTE: With the exception of Social Security, disability determinations by other agencies than DED do not establish disability for Medi-Cal, as different criteria are used. However, medical evidence from any source is considered and reviewed by DED.

g. Item 10 -- Applicant is to indicate highest grade completed or year GED test passed.

h. Item 11 -- Applicant is to indicate language(s) in which he/she can converse and, if available, the name and phone number of a friend or relative available to translate, if needed. If no transiator is available, "none" should be entered in that area.

i. Item 12 -- This information is extremely important in determining the extent of the impairment and its effects on the applicant's ability to function, particularly in cases involving mental or emotional disorders. If incomplete, DED may be unable to determine the extent of the applicant's restrictions which could result in ineligibility.

j. Item 13 -- Applicant is to indicate whether he/she has been employed within the last 15 years. If so, Part II of the form must be completed.

Part II:

Item 4 -- Applicants should enter a job description as well as job title. The job he or she performed may differ from the job described by that title in the Dictionary of Occupational Titles used by DED. If no description is provided, the applicant's case could be erroneously denied due to comparing the applicant's ability to function to an inappropriate past work standard. The description should include

the frequency and weight of any lifting involved; hours spent standing, sitting, and walking; and other exertional requirements. In addition, if alterations were made to the applicant's job functions to accommodate his/her impairments (such as special equipment or changes in duties, etc.), these accommodations should be noted and described. If such accommodation was made, then the applicant may not have performed his/her job as it exists in the national economy and DED must evaluate disability accordingly.

D. Proof of application may be required in some counties with the disability evaluation request in the form of a copy of the signed and dated CA 1. If required, packets submitted without this form will be rejected.

VI. COUNTY STEPS DURING AND AFTER COMPLETION OF THE DISABILITY EVALUATION

A. Upon receipt of the completed disability determination results (MC 221, completed and returned by DED):

1. If DED has determined that the applicant/beneficiary is disabled, approve the application as otherwise eligible or reclassify the case as disabled MN.

   The approval of eligibility or reclassification as a disabled MN person shall be effective with the disability onset date or application date as appropriate.

2. If DED has determined that the applicant/beneficiary is not disabled, take the appropriate denial/discontinuance action on the application or continuing case.

B. Notification to DED of Changes While DED Referral Is Pending

The county shall notify DED immediately in writing (via an MC 221) of the following changes if DED is in the process of making a disability determination:

1. Change in applicant's/beneficiary's address.

2. Change of applicant's/beneficiary's name or message telephone number.

3. Denial or discontinuance of the applicant/beneficiary on the basis of nonmedical information, i.e., excess property, etc.

The county must indicate on the MC 221 that this subsequent MC 221 is to notify DED of a change in the status of a pending referral.

C. DED Addresses

1. Disability evaluation packets from the following counties:

Imperial	Riverside
Los Angeles	San Bernardino
Orange	San Diego

should be sent to:

Department of Social Services
Disability Evaluation Division
State Programs Bureau
P. O. Box 30541, Terminal Annex
Los Angeles, CA 90030
(213) 857-5483

2. Disability evaluation packets from all other counties should be sent to:

Department of Social Services
Disability Evaluation Division
State Programs Bureau
P. O. Box 23645
Oakland, CA 94623
(415) 464-3706

VII. QUESTIONS, INQUIRIES, PROBLEMS

A. Disability Referral Policy and Procedures

Counties should direct questions on these subjects to the Department of Health Services through their county Medi-Cal liaison or disability coordinator.

B. Case Specific Information

When DED fails to complete a disability evaluation within a reasonable time frame, designated county staff should contact DED to ascertain case status in the following manner:

1. Where disability evaluations are not received from DED within 70 days, the county must first submit to the DED office handling that county's evaluations a list of all such cases by applicant/beneficiary name and Social Security number with a request for status information.

   A copy of the request should be sent to:

   Mrs. Virginia McNeely
   Operational Support Analyst
   Disability Evaluation Division
   State Programs Bureau
   P. O. Box 23645
   Oakland, CA 94623

2. If no response is received from DED within 15 days, the county should notify Mrs. McNeely, who will follow up on the request.

Where disability evaluations are consistently not completed in a reasonable time, the Medi-Cal Eligibility Branch, Department of Health Services, should be notified by designated county staff through appropriate channels.

4B -- COUNTY PROCEDURES
DED REFERRALS FOR DISABLED FORMER SSI/SSP RECIPIENTS

Persons under 65 years of age who were discontinued from Supplemental Security Income (SSI) for reasons other than cessation of disability and who are not currently receiving Title II benefits will need to be evaluated by the State Department of Social Services Disability Evaluation Division (DED). This evaluation is necessary because the federal SSI/State Supplementary Payment (SSI/SSP) record of disability is maintained for only 12 months following the SSI/SSP discontinuance. After the 12 months has lapsed, any query to Social Security Administration (SSA) will show that the beneficiary is not disabled and quality control errors may result. Therefore, while eligibility may be granted upon verification of disability by SSA, ongoing disability status must be established by DED prior to the end of the 12-month record retention period.

The following is the referral process:

1. Determine whether or not the applicant/beneficiary is currently receiving Title II disability benefits. If the applicant/beneficiary is receiving Title II disability benefits, no further disability determination is required.

2. If the applicant/beneficiary is not receiving Title II disability benefits, a referral for DED evaluation should be made immediately upon application for Medi-Cal. Only the MC 221 is needed to make the referral on these cases. Indicate on the MC 221 "SSI/SSP discontinued for reasons other than cessation of disability". The MC 223 and MC 220 are not necessary.

3. DED will attempt to adopt the federal disability decision and onset date and will return the MC 221 indicating approval.

   If DED is unable to adopt the federal disability determination, the MC 221 will be returned to the county requesting a full disability referral packet.

4C -- COUNTY PROCEDURES
PRESUMPTIVE DISABILITY

In most cases, an applicant/beneficiary must be determined disabled through a federal or state evaluation process prior to approval of Medi-Cal based on disability. However, applicants/beneficiaries with certain conditions are presumed to be disabled and eligibility may be granted while the Disability Evaluation Division (DED) referral is pending. (Section 50167 (a) (1) (E) requires the county to submit the request for disability evaluation to DED within ten days of the date the Statement of Facts is received. The disability determination referral process is described in Procedure Manual Section 4A.)

In order to be determined presumptively disabled, the applicant/beneficiary must provide the county with a medical statement from his/her physician verifying one of the following conditions:

1. Cancer which is expected to be terminal despite treatment. This category does not include persons whose condition is terminal unless treated.

2. Paraplegia or quadriplegia. Paraplegia means permanent paralysis of both legs. Quadriplegia means permanent paralysis of all four limbs. This category does not include temporary paralysis of two or more limbs or hemiplegia (paralysis of one side of the body, including one arm and one leg).

3. Severe retardation with an IQ of less than 50. This category does not include persons who are comatose or unconscious unless the person's conscious functional IQ would be less than 50.

4. Absence of more than one limb. This category includes persons absent two arms, two legs, or one arm and one leg. Missing fingers, toes, hands, feet, etc., are not included.

5. Amputation of a leg at the hip. Individuals with a leg amputated at the hip are unable to wear a prosthesis and, thus, will be required to use two crutches or a wheelchair.

6. Total deafness. Total deafness is defined as the complete lack of any ability to hear in both ears regardless of decibel level and despite amplification (hearing aid). Persons wearing hearing aids are not totally deaf as some ability to hear is present.

7. Total blindness. Total blindness means complete lack of vision and not legal blindness. Persons wearing glasses are not considered totally blind as some vision is present. The term "glasses" does not include the nonprescription sunglasses worn by some blind individuals.

8. Hemiplegia due to a stroke providing the stroke occurred more than three months in the past. Hemiplegia is paralysis of one side of the body, including one arm and one leg. This condition is often present immediately following a stroke but may improve in the next few months. As a result, a three-month delay in evaluating the applicant's condition is required by federal law. DED cannot develop the disability case until that three-month delay is completed. When application is made in the same month as the stroke occurred, DED must delay case development. However, while presumptive disability is also delayed until the expiration of the three-month period, once that period has expired, the eligibility worker should (providing hemiplegia still exists) grant presumptive disability back to the date of application. The applicant will thus be eligible until DED completes the evaluation.

   NOTE: The three-month period begins the date of the stroke, not the application date.

9. Cerebral palsy, muscular dystrophy, or muscle atrophy with marked difficulty in walking requiring the use of two crutches, a walker, or a wheelchair. The physician's statement must clearly state one of these three diagnoses. Other individuals on crutches, walkers, or using a wheelchair are not presumed disabled unless they meet one of the other impairments indicated.

10. Diabetes with the amputation of one foot. This combination of impairments is considered disabling because the amputation is usually due to circulatory failure caused by the diabetes. Diabetes which has progressed to that point will meet the disability criteria.

11. Down's syndrome with an IQ of 59 or less. In order to be determined presumptively disabled, the physician's statement must clearly indicate a diagnosis of Down's syndrome. Retardation due to any other condition must meet the criteria shown in 3 above. The higher permissible IQ level for Down's syndrome patients is due to the other disabling aspects of that syndrome.

12. End stage renal disease requiring chronic dialysis or kidney transplant. This category does not include acute renal failure requiring temporary dialysis until kidney function resumes.

13. A diagnosis of Acquired Immune Deficiency Syndrome (AIDS) confirmed by reliable and currently accepted tests with one of the secondary conditions recognized by the Social Security Administration as establishing presumptive disability due to AIDS.

    The diagnosis of AIDS must be confirmed by laboratory testing and clinical findings demonstrating one of the following conditions:

    a. Pneumocystis carinii pneumonia or Kaposi's sarcoma.

    b. Pneumonia, meningitis, or encephalitis due to one or more of the following:

        (1) Aspergillosis

        (2) Candidiasis

        (3) Cryptococcosis

        (4) Strongyloidosis

        (5) Toxoplasmosis

        (6) Zygomycosis

        (7) Cytomegalovirus

        (8) Nocardiasis

        (9) Atypical mycobacteriosis

    c. Esophagitis due to one or more of the following:

        (1) Candidiasis

        (2) Cytomegalovirus

        (3) Herpes simplex

    d. Progressive multifocal leukoencephalopathy.

    e. Chronic enterocolitis due to cryptosporidiosis of more than four weeks duration.

    f. Extensive mucocutaneous herpes simplex of more than five weeks duration.

Where a diagnosis of AIDS is suspected but is not confirmed by laboratory tests or clinical findings, disability cannot be presumed. In addition, if a diagnosis of AIDS is made but none of the conditions shown above exist, the county cannot find the person to be presumptively disabled. However, the case should continue to be processed under regular disability evaluation procedures on an expedite basis.

In order to minimize the amount of follow-up activity by eligibility workers and ensure all necessary information is obtained, form DHS 7035, Medical Verification -- AIDS, needs to be completed by the treating physician. A blank DHS 7035 should be provided to the applicant who is then responsible for having the physician complete and sign the form. To establish presumptive disability for an AIDS patient, the physician must have checked "yes" on item I of the DHS 7035 and shown that he/she has confirmed his/her diagnosis with laboratory testing. Currently, there are three tests which are considered reliable and accepted. The first two -- skin testing and T-cell ratio -- are on the DHS 7035. The physician will show these test results in item II of the DHS 7035 by checking "yes" or "no" in either II.A or II.B. The third test, HTLV III, is not on the form but may be hand-entered by the physician. Any one or all of these three tests is acceptable. (The only exception to the laboratory test requirement (Part II) is individuals under 45 years of age who have a diagnosis of Kaposi's Sarcoma. Kaposi's Sarcoma is not contracted by persons under that age unless AIDS is present; therefore, persons under 45 with that diagnosis may be determined presumptively disabled without laboratory tests.) In addition to the test results, one or more of the conditions listed in item III, A through G, must be checked.

Please note that because the form requires certification under penalty of perjury, the statement must be signed by an M.D. Name stamps, signatures by a second party for the M.D., or signatures by other health professionals are not acceptable.

A copy of form DHS 7035 should be submitted to DED with the disability package for any beneficiary granted presumptive disability due to AIDS. If the applicant's medical records are readily available, the applicant may submit copies to be included with the disability evaluation package. In those cases where all the required documentation is submitted with the disability package, counties will usually receive a response from DED within seven to ten days. However, in no case should the county hold the disability referral pending receipt of such medical records.

4D -- GUIDELINES FOR DISABILITY INTERVIEWS AND ELIGIBILITY WORKER OBSERVATIONS

Because of the direct client contact, county welfare department intake staff are in an excellent position to provide valuable observations about the physical and/or mental status of applicants seeking Medi-Cal benefits due to a disability. Either form DHS 7045, Worker Observations-Disability, or the CWD Representative Comments section of the MC 221 should be used to present relevant details; these can make the development and determination of disability more timely, economical, and accurate. In no case will eligibility worker comments or observations adversely affect the disability evaluation. These comments are used solely to help identify additional impairments which may not have been reported. The Disability Evaluation Division (DED) is aware that eligibility workers generally have no medical background and will not use eligibility worker comments to determine the condition of the applicant or to deny disability.

The DHS 7045 is an optional form made available for use in recording comments. The types of observations provided on the form are mainly physical in nature due to the difficulty in providing adequate descriptions of mental and/or emotional problems in one or two words. Therefore, any observations an eligibility worker may have regarding an applicant's mental or emotional condition should be entered by hand in the appropriate comment section on the MC 221 or DHS 7045. Please note that severe mental and emotional impairments are frequently not admitted by applicants. Psychological impairments may severely restrict an individual's ability to work and, when obvious to an eligibility worker, should be described to DED.

Use of Worker Observations by DED

It should be noted that DED has discontinued the practice of screening out applicants. Currently, all disability applicants receive complete medical development regardless of the basis of the alleged disability. The information reported on the DHS 7045 or MC 221 will provide DED with information which will help identify all potential physical/mental conditions during the disability evaluation. Too frequently applicants will fail to identify all impairments and will only note those conditions which they feel are significant or for which they need treatment. Impairments which are treatable are not considered disabling, regardless of severity, unless the impairment can be expected to last 12 months despite treatment. For example, if an eligibility worker notes that an applicant limped, DED will ask the applicant and his/her physician if he/she has any impairment of the foot, ankle, leg, or hip. Please note that this example comes from an actual case. An applicant applied for Medi-Cal as a disabled person based on uterine cancer and failed to mention on the MC 223 or to her eligibility worker that she also suffered

from an amputated foot and three crushed vertebrae. She did not desire treatment for those two conditions and also felt that the cancer was the more serious condition. Her cancer was treatable and, therefore, not considered disabling. However, upon reevaluation she was found disabled based on her other impairments.

Therefore, it is extremely important that all impairments be identified. Eligibility worker observations can play an important part in the evaluation process by identifying potential impairments.

The following are guidelines to assist county welfare department interviewers in the completion of the Comments section and should be used only as a reference; they are not all-inclusive nor do they exclude any other pertinent observations. This guide includes some of the more frequently occurring actions or demeanor which may be observed and should be reported. The sample descriptive statements may also be helpful.

The county welfare department interviewer should be sensitive to the type of disability alleged and use common sense in the type of observations made. Any indication that the disability may be other than the alleged one(s) or that additional conditions may exist should be reported.

I. PHYSICAL MOBILITY

Observe the applicant walking, standing, and sitting. Record observation of any assistance required either by another person or through the use of devices such as braces, canes, or crutches. Difficulty with walking, difficulty in standing up, and problems with sitting for prolonged periods of time are examples of details which should be reported.

Observe the applicant's use of hands and arms. Difficulties with stiffness or lack of control in the use of extremities should be noted along with such things as joint swelling, shaking and trembling, and inability to flex fingers. Be attentive to difficulties in writing.

II. PHYSICAL APPEARANCE

Height and weight should always be noted. The applicant should be asked when he was last weighed and if there have been any recent major weight changes. Note if the applicant appears unusually thin, overweight, short, tall, or malnourished.

Any unusual skin condition warrants attention such as scaling, peeling, or unusual color. For example, is the client especially red of face or is the client's appearance colorless? Report the presence of scars and signs of disfigurement or deformity, the absence of any extremities, and the use of prosthetic devices such as artificial legs, eyes, etc.

III. OTHER PHYSICAL PROBLEMS

Other observations might include any breathing difficulties noted, frequent coughing, and rapid respiration. Any indication that the applicant is under the influence of drugs, alcohol, or medication which might affect physical or mental functioning should be reported.

IV. SPECIAL SENSES

Observe any problems with hearing, seeing, and speaking. Mention any use of hearing aids or glasses. The interviewer should note if the applicant can only hear speech at high volume levels; if the applicant had to take special measures to read the printed forms; and if the applicant's speech was difficult to understand, slurred, or impeded in any way. Can the client read the MC 223 or is their sight so poor or impaired that it cannot be read without difficulty?

V. MENTAL AND EMOTIONAL STATUS

Observe any signs of disorientation to time, place, or person, as well as any indications of emotional distress. Attention should be paid to unusual mannerisms, inappropriate dress, signs of restlessness, and unusual laughter or crying. Any difficulties in comprehension not due to a language barrier should be mentioned along with wandering conversation, inappropriate response, limited attention span, and poor memory. Also worth noting are signs of deterioration of personal habits such as poor hygiene or grooming.

VI. EXAMPLES OF USEFUL COMMENTS

A. Mr. D had noticeable difficulty walking and sitting. He wore a brace on the right leg. This leg appeared to be shorter and smaller than the other leg. He walked with a limp and braced himself as he sat down. The claimant had full use of his upper extremities.

B. Mrs. L arrived for her appointment at the correct time but on the wrong day. It was difficult to obtain information from her as she rambled on about various subjects. She seemed confused and disoriented and her memory was poor. She was very vague when discussing her alleged illness.

4E -- DISABILITY EVALUATION DIVISION PROCEDURES FOR TITLE XIX DISABILITY DETERMINATIONS

The State Programs Bureau of the Disability Evaluation Division (DED) in the State Department of Social Services is responsible for the determination of disability (linkage) necessary to establish eligibility for the Title XIX Disabled Medically Needy program. County welfare departments are responsible for the nonmedical eligibility determinations. DED procedures follow.

I. APPLICATION PACKETS AND REEXAMINATION REQUESTS

Upon receipt of an application packet or reexamination request, DED shall take whatever actions are necessary to obtain medical evidence for a disability determination when it appears that a disability determination cannot be made from available medical evidence.

When a consultative examination is required, DED shall contact the closest (to the applicant) available cooperating source for an appointment and will notify the applicant.

After a disability determination has been made, the completed original MC 221 shall be returned to the county welfare department. The determination can be expected within 60 days after receipt by DED, except when there is a concurrent Title II or Title XVI application pending (see III.A below), the treating physician fails to provide medical evidence, or federal law requires that development of a case be delayed (example: the condition of stroke victims cannot be reviewed until three months after the date of the stroke).

II. ONSET DATES FOR TITLE II AND TITLE XVI (SSI/SSP) ELIGIBLES AND TITLE XIX MEDICALLY NEEDY DISABLED PERSONS

A. The county obtains the disability onset date from Social Security Administration. However, the county must submit a disability evaluation packet to DED if the onset date is after the period for which the applicant is requesting Medi-Cal.

B. For those persons whose Supplemental Security Income/State Supplementary Payment (SSI/SSP) or Title II determination is pending at the time of their request for retroactive coverage, DED shall follow procedures in III.A and B.

III. APPLICATIONS FOR PERSONS WHO CLAIM TO HAVE A TITLE II OR TITLE XVI DISABILITY EVALUATION PENDING

A. The county must submit a disability evaluation packet to DED in cases where the applicant claims he/she has an application for Title II or Title XVI disability benefits pending. The reason the packet is needed is that applicants frequently believe they have applied for those two programs but have in actuality applied for worker's compensation, state disability benefits, etc. If DED discovers that no federal evaluation is being performed, all forms necessary for the medically needy evaluation are available if the complete packet has been submitted. If the complete packet is not submitted, DED must return the case to the county. The eligibility worker must contact the applicant and have him/her complete all necessary forms and then resubmit the packet to DED. Thus, submission of the complete packet avoids unnecessary case delays.

B. If a Title II or Title XVI application is pending, DED shall hold the MC 221 until the final federal disability determination is made. DED will notify the county that the case is being held. In no case is the county to deny the application due to the pending federal determination. The application must be held open until the DED determination is completed unless other criteria render the applicant ineligible.

C. When the final federal disability determination is made, DED shall return the MC 221 to the county with the onset date, reexamination date (if applicable), or the original date of the federal denial.

D. DED will process the packet when there is no pending federal application, the county has indicated the disability determination is urgently needed, or if the federal determination will not be completed within reasonable time limits.

IV. PREVIOUS TITLE II OR TITLE XVI DENIALS

If an applicant has previously been denied Title II disability benefits, or a Title XVI SSI/SSP cash grant based on lack of disability, DED shall:

A. Where the denial is within 90 days prior to the Medi-Cal application, automatically deny the Title XIX application (unless the county informs DED that the applicant alleges there has been a deterioration in his/her mental/physical condition) and return the MC 221 to the county with a notation of the original date of the denial.

B. Where the denial date was more than 90 days prior to the Medi-Cal application, process in accordance with 4A.